Government of the District of Columbia **Department of Health**

Community Health Administration Bureau of Child, Adolescent and School Health **Immunization Registry**



Immunization Record Non-Disclosure Form

Please complete this form if you are 18 years of age or older or an emancipated minor or the parent or guardian of a minor and do not wish your or your child's immunization record to be shared with authorized users of the DC Immunization Registry outside the DC Department of Health (DOH).

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I □ Individual	$or \square Parent$	Guardian (first n	do not ame / last name)	want the immur	nization information of
first/	/ middle/	last name	$\frac{1}{Date \ of \ Birth}$	(month/date/year)	\square M \square F Gender (check one)
Address/		//		/ / / Zip Code	o be shared with
DC Immuniz	ation Registry	users outside th	e DC Departm	ent of Health (I	ООН).
authorized, no have access to Immunization school reques	on-DOH users to the immunized Registry. I use for informal to the title is best to	s of DC Immunization record, as understand that button must be according to the control of the c	zation Registry will the provid by signing this companied by a	t. The DC Department of the DC	I not be shared with artment of Health will ented the shots in the ealthcare provider or I release. I also ization record for
Signature of Ad	ult Individual or Pare	ent/Guardian		Date ((month/date/year)
(Health care p	rovider, please	place a copy in ti	he patient's med	ical chart.)	
Please FAX of	r MAIL this fo	orm to:			

DC Immunization Registry Fax: 202-541-5907 Phone: 202-576-7130 6323 Georgia Avenue, NW Suite 305 Washington, DC 20011



